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ABSTRACT

This report discusses the ongoing movement to provide health care and health information to adolescents through school-based clinics and other programs. The report begins with an overview of programs, focusing on: the unique health needs of adolescents; the growth in the number of school-based clinics; goals and objectives of the special programs; types of services they offer; clinics' involvement with special issues surrounding family planning; the issue of abortion; establishment and management of clinics; staff; populations served; the physical set-up of the clinic in the school; parent involvement; the relationship between clinic and school; reasons for the clinics' general success; evidence for the clinics' success; current research on clinics; costs; funding; and limitations of the clinic model. The next part of the report presents an outline of recommended steps to follow in order to implement a school-based clinic. The report concludes with a selected bibliography of resources and a list of addresses of school-based clinics. (KH)

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SCHOOL-BASED HEALTH CLINICS:

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An Emerging Approach to Improving Adolescent Health and Addressing Teenage Pregnancy

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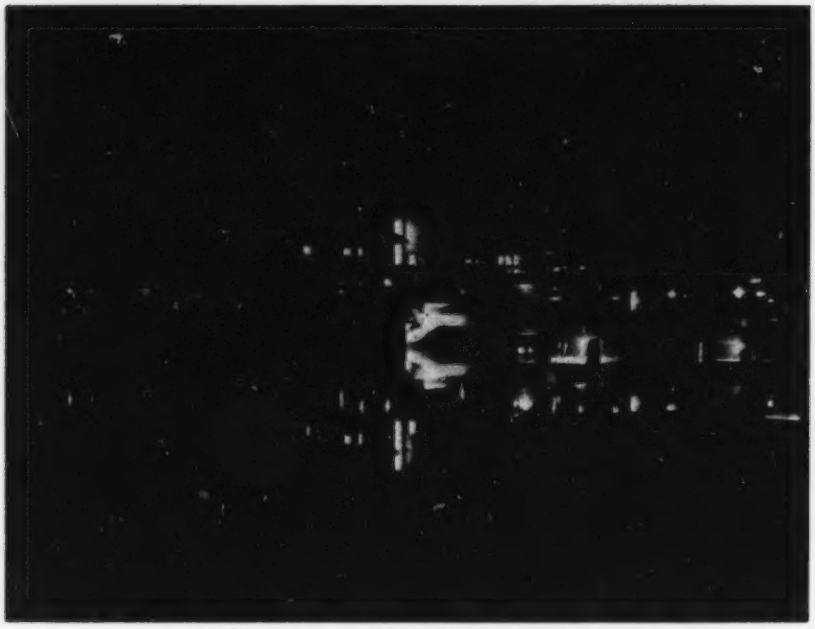

A report based upon the conference, "School-Based, Multi-Service Health Clinics: Exploring a New Program Approach," sponsored by The Urban Affairs Corporation and the Center for Population Options, and funded by the Ford Foundation, September 28-30, 1984 at the Woodlands Inn, Houston, Texas.

A number of junior and senior high schools in this country have opened health clinics which provide a variety of health services ranging from sports physicals to family planning and prenatal care. These clinics are based either in the schools or on the school grounds. Because they developed quite independently of one another, few clinics knew of each other, and even fewer had shared their own approaches, their concerns, their successful (and unsuccessful) solutions to problems, or their thoughts about the future. Consequently, the Center for Population Options, which is devoted to reducing unintended teenage pregnancy nationwide, and the Adolescent Primary Health Care Center of The Urban Affairs Corporation, which implemented a school clinic in Houston, organized the conference. Seventy-five people representing 11 clinics and several other organizations attended.

This report summarizes some of the material presented at that conference and provides other information subsequently obtained about these school-based health clinics. It is designed both to inform others about the clinics and to assist those who are thinking about opening their own clinics.

Both the conference participants and we, at the Center for Population Options, greatly appreciate the Ford Foundation's support of the conference and the writing of this report. We also wish to acknowledge the William T. Grant Foundation for funding an evaluation of clinic programs which has also contributed to this report.

If you are interested in school-based clinics or have additional questions about these clinics, we encourage you to contact The Support Center for School-Based Health Clinics at the Center for Population Options.

SCHOOL-BASED HEALTH CLINICS:

An Emerging Approach to Improving Adolescent Health and Addressing Teenage Pregnancy

by

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April, 1985

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AN OVERVIEW OF PROGRAMS

Adolescent Need for Health Care

Many people believe that adolescents are remarkably healthy and do not experience the same need for health services as their younger siblings or their older parents. However, adolescents not only experience some of the same health problems as the general population, they also experience other problems that characterize puberty and adolescence—menstrual problems, growth disorders, and acne, to name a few.

Furthermore, teenagers frequently report the need for assistance with developmental tasks involving the changing nature of their relationships with their families, members of the same and opposite sex, and school. Thus, many teenagers experience depression, loneliness, tension, and psychologically induced disorders such as anorexia and bulimia.

Many teenagers feel invulnerable and take risks. Some teenagers use drugs and consume alcohol to excess; some drive too fast or too poorly and become involved in car accidents; some engage in unprotected sexual activity and become pregnant (or get someone pregnant). Consequently, motor vehicle accidents are the greatest cause of death among teenagers, and more than a million teenagers between the ages of 10 and 19 become pregnant each year. Moreover, more than one-third of all teenage girls become pregnant before they turn 20 (Alan Guttmacher Institute, 1981).

Of course, when those teenage girls become pregnant, their health care needs escalate. They need instruction about nutrition and require both prenatal and perinatal care. Without such care, the health risks to the mother and baby are significantly higher than among older mothers.

However, in many communities, adolescents are not receiving the health care they need. Whereas special health care programs have been designed for infants and toddlers and for poor or needy adults, few programs are designed specifically for young people. Throughout the nation, about 15% of adolescents age 16 to 17 report no regular source of medical care, in comparison with 7% for children under the age of 6. (Green and Horton, 1982). According to Mark Raifman, MD at Long Beach Memorial Hospital, adolescents are the most medically underserved group in the United States. In economically de-

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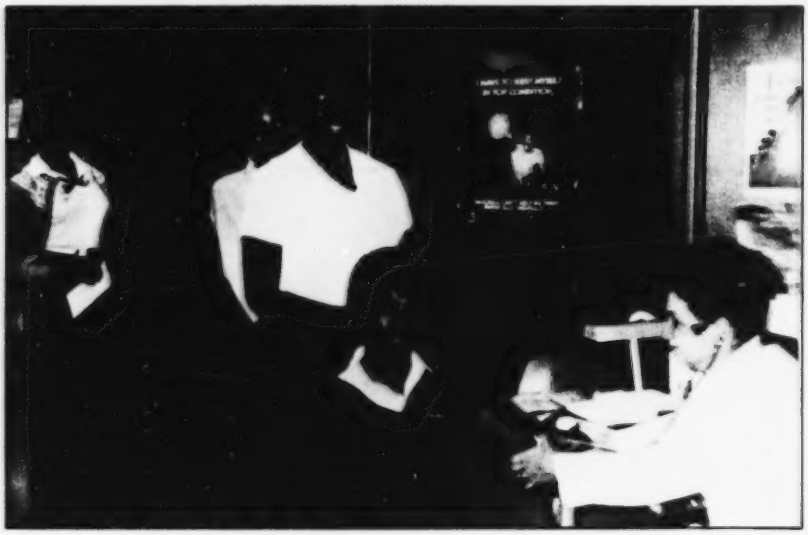

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prived areas, the percentage of underserved adolescents is much greater. For example, before one community opened a school clinic, more than 50% of the teenagers in that community did not have a family physician.

One of the greatest unmet needs facing adolescents is the need for family planning services. Over two-thirds of the five million sexually active teenage girls are not receiving family planning services from clinics. Only one in seven clients served at federally funded family planning clinics are teenagers younger than age 18 (Alan Guttmacher Institute, 1985).

The difficulties in obtaining adequate health care are aggravated by changes in the American family structure. During the last several decades there has been a great increase in both the number of single parent families and the number of families where the single parent or both parents work. Consequently, it is now more difficult for one or both parents in a family to schedule time to take their children to a doctor's office or clinic and to teach them when and how to use those services.

These trends are illustrated by the comments of an Ohio mother of three:

> "When I was young, I remember that my mother—or sometimes my grandmother—took me to the doctor when I was sick. Now, I have three children. I'm divorced. I support this family. I leave for work at 7:30 in the morning and I don't get home until after six. When my kids get sick, I don't know what to do. There isn't a doctor within 10 miles. Sometimes I try to get a neighbor to take them to the emergency room." (Robert Wood Johnson, p. 6, 1979)

And even when teenagers do have access to a family doctor or clinic, they commonly do not have specially designed services provided by specially trained providers. Teenagers often feel that they have outgrown pediatric services and do not want to go to clinics where waiting rooms are filled with babies and small children. Yet, they are also reluctant to go to clinics or medical offices for adults, fearing that their confidentiality will be violated and that their behavior and concerns will be judged negatively. Their access to these clinics is also limited by the clinics' hours, rigid appointment schedules, long waiting periods, and significant fees.

These limitations are especially illustrated by their impact upon sexually active teenagers in need of family planning services. While most sexually active teenage girls do not want to become pregnant, and most teenage boys do not want their girlfriends to become pregnant, many of these teenagers are not aware of their need for family planning, nor do they know where family planning services are provided. In some communities, they must take unfamiliar bus routes to equally unfamiliar family planning clinics. As a result, the difficulty and fear of the unknown prevent them from going to the clinic. In other

communities, clinics may be closer, but they often lack both the promise of anonymity and the specialized programs teenagers' needs demand. Furthermore, they may be open only during hours that are inconvenient for teenagers who are in school, and they may allow insufficient time for adequate counseling of teenagers. In an effort to reduce costs, some family planning clinics allow only 10 to 15 minutes for counseling a patient on the methods of birth control and others have eliminated individualized counseling completely. Teenagers who are less knowledgeable about contraception and who have additional issues to discuss may need much more time than this. Because of these problems and others, many teenagers fail to use and return to family planning clinics.

School-Based Clinics: A Movement to Provide Needed Health Care

In response to those clear needs, numerous agencies concerned with the health care of adolescents have developed programs for teenagers. In the past, most of those programs were not located in schools, but were located in more traditional health settings.

However, in 1968, members of the Department of Pediatrics at the University of Texas Health Science Center, Dallas, became committed to providing health care to children from birth to age 18. First, this Children and Youth Project opened clinics in two elementary schools. Then, under the direction of Dr. Patrick Laruffa, the project opened a high school clinic in September 1970 to continue the care. That clinic was staffed by a physician, social worker, school nurse, and clerk. Although it did not emphasize family planning, it is the first known clinic to provide both health and family planning services on a high school campus. Its hours of service quickly expanded from three to five days per week and its staff increased.

Only a few years later, in 1973, under the leadership of Dr. Laura Edwards, the Maternal and Infant Care (MIC) Program of the St. Paul Ramsey Hospital opened a clinic in Mechanic Arts High School in St. Paul. That school closed three years later, and students were transferred to two other schools. The Ramsey MIC program then opened clinics in both of those schools and eventually two additional schools. All of these St. Paul school-based clinics included family planning services.

Despite this successful beginning, the number of such clinics remained small for several years. Although the staff at these clinics openly shared their experiences and documented their success in professional journals, few additional clinics were opened elsewhere. School-based clinics did open in Galveston, Hartford, Cambridge, and Posen-Robbins (Chicago), but these clinics did not offer family planning services.

One of the greatest unmet needs facing adolescents is the need for family planning services. Over two-thirds of the five million sexually active teenage girls are not receiving family planning services from clinics.

Currently there are at least 31 known clinics in 18 different cities and communities. Indeed, there are at least another 25 communities beginning to develop programs. . . .they seem to manifest a grassroots movement.

During the last five or so years, however, an increasing number of junior and senior high schools in this country have opened, on campus, clinics with family planning. Whereas initially the clinics were located mostly in the middle part of the country ranging from St. Paul to Dallas and Jackson (Mississippi), now they are expanding westward and eastward. Currently there are at least 31 known clinics in 18 different cities and communities. As people become more aware of the problems of adolescent health and pregnancy, an increasing number support school-based clinics as an effective solution. Indeed, there are at least another 25 communities beginning to develop programs. Although many of the existing clinics have received financial support from national foundations or agencies, many of them developed quite independently from one another, and they seem to manifest a grassroots movement.

What Are Their Goals and Objectives?

Most of the programs strive to improve the overall physical and emotional health of teenagers. They try to do this in two important ways—by promoting healthy lifestyles so that adolescents will have less need for health care and also by improving that health care when adolescents do need it.

Through education and counseling, clinics strive to:

- increase adolescents' knowledge of preventive health care,
- improve decisions about health matters,
- reduce their risktaking behavior,
- help develop health-promoting behaviors.

Through EPSDT screenings, physical exams, and intake interviews, many clinics strive to:

- provide earlier detection of chronic disorders and earlier treatment of acute problems,
- detect signs of emotional stress and other psychosocial problems.

Through provision of actual health care, clinics strive to:

- teach adolescents how to use the health care system,
- treat illnesses and health problems,
- facilitate use of birth control and thereby reduce pregnancy and repeat pregnancy,
- improve prenatal care of adolescent mothers and thereby reduce infant mortality and morbidity,
- provide support for mental health problems.

And finally, through arrangement of referrals, clinics strive to:

- enhance interagency cooperation and facilitate continuing, comprehensive medical care for students.

Because teenage pregnancy has a variety of negative consequences, several clinics have focused on the reduction of teenage pregnancy as a major goal. However, none of the clinics deem this their sole purpose, for all of them are concerned with the overall health of adolescents.

What Kinds of Services Do They Offer?

The school-based clinics, as a group, provide a wide variety of services, including athletic physicals, general health assessments, laboratory and diagnostic screenings (e.g., sickle cell anemia and STD screenings), immunizations, first aid and hygiene, EPSDT testing, family planning counseling and services, prenatal and postpartum care, day care, drug and alcohol abuse programs, nutrition and weight reduction programs, family

counseling, and others. These numerous services clearly demonstrate the clinics' commitment to general health care.

Nevertheless, the clinics do differ considerably from one another, with some emphasizing some services, and others emphasizing other services. In some cases, these variations are due to the differing needs of the students and the goals and philosophies underlying the clinics; in other cases, they are due to practical differences, such as the availability of funding, state or local restrictions, etc.

To better determine which services are most emphasized, we surveyed 10 organizations running 23 school-based clinics. The results of that survey, presented in Table 1, indicate that clinics do focus upon general health care, providing primary health care, sports physicals, laboratory screenings, STD tests, counseling about sexuality and other problems, and a range of family planning services.

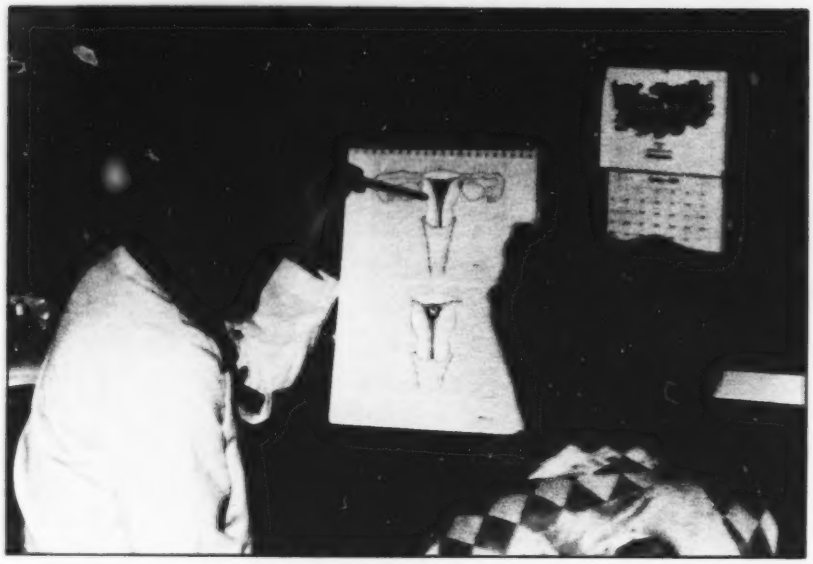
In order to be included in this report, the programs must facilitate family planning. At a minimum, they all do counseling, make referrals, and do follow-up after the referrals. Almost three-fourths of them also conduct pelvic exams and write prescriptions for birth control. About half actually dispense birth control methods at the clinic.

The clinics' policies about birth control are often consistent with their policies about other treatments: if the clinics write prescriptions for other medications, they also write prescriptions for contraceptives; if they fill other prescriptions, they also fill prescriptions for contraceptives. Thus, family planning is an integrated part of this adolescent health care delivery system.

Table 1:
Percentage of Programs Offering Different Types of Health Services*

Type of Service	Not an Activity	A Minor Activity	A Major Activity
Physical exams for sports	20%	0%	80%
Laboratory screenings	0	0	100
STD tests	0	10	90
Immunizations	10	50	40
Nutrition education	0	40	60
Drug and substance abuse programs	40	50	10
Family counseling	20	40	40
Sex education in classroom settings	20	50	30
Individual counseling about sexuality	0	0	100
Gynecological exams	0	20	80
Referrals for birth control prescriptions	50	30	20
Actual birth control prescriptions	20	0	80
Dispensation of birth control methods	50	10	40
Follow-up exams for family planning users	10	10	80
Pregnancy testing	10	10	80
Prenatal care	20	0	80
Pediatric care for infants of adolescents	30	20	50
Day care	70	0	30
Dental services	40	40	20
Referrals to other agencies	0	50	50

**Preliminary data from ten organizations running 23 school-based clinics.*



Are There Special Issues Surrounding Family Planning?

At most clinics, family planning and pregnancy related medical services account for a small percentage of student visits. For example, at the Houston clinic about 10% of the visits are typically for family planning. Nevertheless, reducing the number of student pregnancies is often one of the most pressing needs of the schools, and by definition all of the clinics are involved in family planning.

Many of the programs include a discussion of sexual activity as part of the first visit during the routine health assessments of all clients, female and male. If students are sexually active, or planning to engage in sexual relations, they are encouraged to think through a number of issues and options, including abstinence. Clinic staff do not encourage sexual activity. Instead, in a non-threatening, non-judgmental manner, they discuss the complexities, responsibilities, and consequences of early sexual behavior.

If it is determined that students are currently sexually active and will continue to be sexually active, they are encouraged to use some form of contraception. At these clinics, oral contraceptives tend to be the preferred method of teens, followed by a variety of barrier methods. There is no evidence indicating that the availability of contraception at the clinics increases sexual activity.

As noted above, nearly all the clinics conduct pelvic exams. About half the programs then make referrals to outside agencies for prescriptions. Those programs typically make a considerable effort to follow-up on services, thus ensuring client compliance. About 80% of the clinics write the prescriptions there in the clinic, while about 50% of the clinics fill those prescriptions. These additional services may improve patient access to contraceptives and their compliance with prescriptions.

In both instances, continued patient compliance poses a real challenge to health clinic practitioners. Many adolescents fail to use properly and continually a method of birth control, even after they have obtained that method. Consequently, most programs emphasize that frequent contact with contraceptors is important and

schedule frequent return visits; some schedule return visits one week after dispensing of the birth control method, and monthly thereafter, while a few schedule return visits every three months.

During this follow-up, the staff answer any questions the student has, reemphasize the important principles of using that method of birth control, make sure the student is not having any side effects, and make sure that the student is still properly using the method of birth control if still sexually active. Thus, this follow-up continues to educate the students while improving their overall compliance.

When students miss their appointments, the staff contact the students either in school or over the telephone. In both cases confidentiality is maintained.

Some of the clinics try to involve males in family planning. At some clinics, males tend to be receptive to family planning counseling and often request condoms. These boys usually initiate contact with programs through routine athletic physicals, but also provide information about their sexual activity as a part of their medical history. Several programs report that the level of participation by boys is directly related to the presence of male staff.

How Do the Clinics Handle Abortion?

None of the clinics performs abortions. Although a few clinics may discuss with pregnant teenagers all their legal options, few, if any, of them make referrals to abortion clinics. At these clinics, most of the teenagers receiving positive pregnancy tests do go to term.

Who Sets Up and Runs the Clinics?

The day to day management of the various school-based clinic programs is often dictated by the types of medical and social services available, the sponsoring (funding) entity, and any state or local restrictions. Although most of the existing programs are physically located within schools, with only one exception the direct day to day management of these programs is not a function of the particular school system's administration.

A wide variety of organizations have recognized the unmet needs of adolescents and have set up and run school clinics. There are at least six such organizational types:

- **Hospitals and medical schools.** Staff members in departments of pediatrics or obstetrics/gynecology were among the first to initiate clinics in schools. Such clinics tend to be larger and more comprehensive (e.g. St. Paul and Dallas).
- **Community clinics.** In one case a health center (Jackson-Hinds Health Center) opened branch clinics in the high schools. In Cleveland, a free clinic provided the initiative.
- **Departments of public health.** At least one public health department (in Minneapolis) has used federal Maternal and Child Health funds to open clinics in schools.
- **Private non-profit organizations.** At least two non-profit organizations (e.g. the Adolescent Resources Corporation in Kansas City and the Urban Affairs Corporation in Houston) obtained funding from a variety of sources, set up the clinics, and then subcontracted with hospitals and other agencies to provide services in the schools.
- **Family planning clinics.** A Planned Parenthood affiliate in Muskegon, Michigan, is operating a single clinic in a high school and another in a junior high school. These clinics have hired medical practitioners and provide other health services along with family planning.
- **School systems.** In Gary, Indiana, the school district obtained funding from other sources, and hired its own staff to run the clinic in one of its high schools.

Clearly a variety of different groups have demonstrated their ability to set up and manage effectively these programs. Yet, at this stage, it is too early to determine which type of organization best administers the programs.

Most, if not all, of the programs employ a single administrator or program director who coordinates the program's activities. These administrators are crucial to the success of the clinics. They may act as the medical directors and may be involved in actual service delivery, or they may have a strong background in clinical services and/or public health administration.

Most of the directors need broad expertise in developing cooperative and contractual relationships with a wide range of other agencies to provide needed services to adolescents. As indicated earlier, the comprehensive programs include general medical and acute care service.

coupled with a host of counseling and referral services and, in some instances, day care services. Thus, the directors or their staffs must constantly monitor the community linkages to ensure that clients follow through on referrals and that there is communication with the referral agency.

Program directors also usually have the responsibility for program design, implementation and ongoing evaluation. This is a constant process, due to the very nature of school-based populations. At some clinics, the needs of the students seem to vary from year to year. Thus, the directors need to keep their programs flexible and to change them when needed.

Another important function for administrators can be broadly defined as public relations. Because the programs are innovative, and sometimes, controversial, they need a strong base of community support.

Most programs also have advisory boards or committees to provide support for these projects and to oversee the clinic. These boards typically include representatives from the community, medical institutions, the school, and parents. Often they set broad policies for the clinic and are usually involved with securing continual funding for the program.

How Are Clinics Staffed?

Most clinics rely heavily upon nurse practitioners and either social workers or counselors. The smallest clinics with the most limited funding commonly employ a nurse practitioner and social worker or counselor about half time. If funds permit, they also have a medical assistant. The nurse practitioners work under written medical protocols established by the physicians associated with established medical institutions. Sometimes those doctors also visit the clinic for specific appointments, review and cosign charts, and perform other quality assurance measures.

Most youths who visit the clinics would otherwise be medically underserved because of their socio-economic status. Like most teenagers, they lack sophistication in the uses of medical services.

The larger clinics tend to have full-time nurse practitioners, counselors, and medical assistants. They also employ part-time or full-time physicians, health educators and nutritionists, counselors specializing in drug and alcohol abuse, clinic receptionists, and occasionally dentists and dental assistants. Of course, they also have directors or administrators.

As much as possible, the clinics select staff that both enjoy working with adolescents and are trained to do so. For example, the nurse practitioners and physicians are typically trained in pediatrics or obstetrics and gynecology, and nearly all the counselors are either trained or experienced in working with adolescents.

What Populations Do the Clinics Serve?

Most of the school-based clinics are located in low-income areas, while many, but not all, are in inner-city schools. Most of the schools are in predominantly black areas, but a few (e.g. Minneapolis) serve a majority of whites and a few (e.g. Dallas, San Francisco, and St. Paul) serve Hispanic, Filipino, or Southeast Asian students.

To a large extent, these youths are medically underserved because of their socio-economic status. Like most teenagers, they lack sophistication in the uses of medical services. Sometimes they are initially suspicious and mistrustful of clinic staff and unfamiliar with routine clinical procedures.

For all these reasons, the clinics are filling unmet needs and do not normally compete with established medical providers. In fact, one clinic director commented that medical providers in that area "didn't want to be bothered by these teenagers who can't pay."

How Are Clinics Set Up Physically in the School?

Many school-based clinics operate within the regular school building. They have converted a variety of rooms—classrooms, locker rooms, storage rooms, former nurse's or counselor's offices, and other rooms—into examination rooms, counseling or educational areas,

Most, if not all, of the clinics obtain written consent from the parents of each student before that student can receive medical services from the clinic.

and reception areas. In some clinics, the amount of space is ample; in others it is much less than needed.

Because of school restrictions on non-students entering the building, these clinics often cannot serve teenagers who have dropped out of school. This is an important population of young people who could benefit from such services, because their health needs are unusually high and they are especially likely to become pregnant.

Some clinics have overcome this problem by opening their clinics on the school grounds but in separate buildings so that they can serve students from that school, students from other schools, and dropouts. A few clinics have converted old and unused buildings; others have combined two portable classrooms to create a physically separate clinic.

This approach seems to work well. For example, the physically separate clinic in Dallas serves annually about 1,200 students from the high school where the clinic is located and about 2,000 other adolescents from the community.

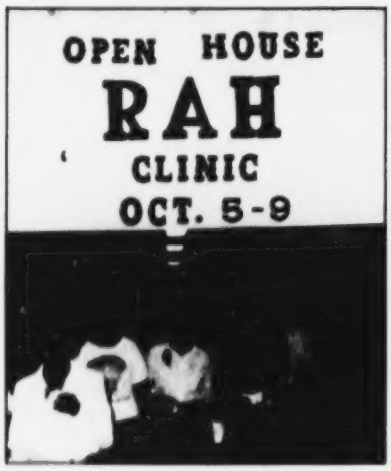
All of the clinics both inside and outside the school buildings are divided into separate rooms. Like any small community clinic, they have a waiting room, one or more examination rooms, and sometimes separate rooms for counseling. The larger clinics also have rooms for doing laboratory work and storing pharmaceuticals.

Frequently, the clinics are decorated in a cheerful and colorful manner; their walls are often brightly painted and enlivened with informative posters. Some clinics also supply pamphlets and other educational materials so that students can read about health issues while they are waiting to be seen.

How Are Parents Involved?

Most, if not all, of the clinics obtain written consent from the parents of each student before that student can receive medical services from the clinic. Each fall when the students come back to school, most clinics send home to the parents a written description of the clinic and all of the health services it offers. At some sites, the parents have the option of consenting to most services, but denying specific ones. In practice, the vast majority of parents request that their children be given all needed care.

One site in Chicago even requires that one or both parents participate in the initial intake interview. This process is, of course, time-consuming, but it does further involve the parents, acquaint them with the clinic, and give the clinic staff more information about the home en-



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vironment. Most clinics strongly encourage their patients to discuss any health problems, as well as sexual decisions, with their parents.

What Are the Relationships between the Clinics and the Schools?

Clinics make a considerable effort to become well integrated into the schools. The staff often try to get to know the administration, as well as the teachers and counselors. In fact, many have learned that an effective way to gain early acceptance is to offer free athletic physicals to the football players and other athletes.

If there is a school nurse, she often becomes part of the clinic team. Although school nurses may initially have reservations about more highly trained nurse practitioners opening a clinic in their school, after a while the nurses feel that they are, in fact, more productive and that the students are receiving better care.

Students go to the school clinic just as they would otherwise go to the nurse's office. Similarly, the school clinic pulls students out of class for appointments, just as a school nurse would. As much as possible, the clinics accommodate students who just walk into the clinic. However, some of them have found that they can minimize the amount of time that students are out of class by scheduling a few or perhaps many appointments. Whenever possible, they try to schedule these appointments during the students' study hall or during other classes that can be more easily missed.

Overall, the existence of a clinic on school premises decreases the number of classes that are missed. Without the clinic, the student might be sent home for the entire day or might have to spend most of the day getting care somewhere else. With the clinic on campus, some of those students only need to miss a single class. Several principals have commented that the clinic did reduce the numbers of absences and disruption resulting

from health problems.

The clinic staff sometimes give presentations to various classes. In so doing, they not only serve an educational function, but a recruitment function as well. When the clinic staff give presentations, the students can see them, get to know them a little, and thereby feel more comfortable going to them in the clinic.

Some of the clinics also organize other school activities, such as health fairs and newsletters. These tend to be popular with the students.

However, the efforts of the clinics to become integrated into the school do not extend to the clinic records. All clinic records are strictly confidential, and no school personnel are allowed to see them. This requirement insures the protection of the students.

Why Do Clinics Work?

There is an old saying in real estate that the three most important factors in determining the value of real estate are location, location, and location. In this same vein, one can claim that the three most important reasons why school clinics work are location, location, and location.

Schools, after all, are where the young people are. And according to the providers, being there does offer a number of obvious advantages:

- The clinic is extremely accessible—adolescents don't have to take a bus or drive to another part of town, nor do their parents have to come and pick them up.
- It is familiar—students are in the school daily during the school year. Many students are in the clinic for a variety of health and educational reasons and become familiar with the clinic's other services and procedures.
- It is continually available—students do not have to make an appointment for many services.
- Students know that their friends use the clinic, and thus peers indicate that it is an "ok" place.
- Clinic visits are either free or have a minimal annual cost.
- Obtaining services is confidential. Because students visit the clinic for a wide variety of reasons, no one automatically assumes that an appointment at the clinic is for any particular reason.

. . . last year the clinic in Dallas found previously undetected health problems in an estimated 20 to 30% of its patients, including more than 100 undetected heart murmurs. Each year that same clinic treats more than 3,200 youth in 11,000 clinic visits for a wide array of health problems.

- Because the clinic is strictly an adolescent clinic, it can hire staff that are fully accustomed to and skilled at working with the adolescent population.
- The clinic staff can better integrate health instruction in the classroom with health care in the clinic.
- When a student comes to the clinic ostensibly for other reasons, the clinic staff can take that opportunity to see if the student wants to discuss sexual behavior and birth control.
- If a female student is sexually active and needs to use birth control, the clinic staff can counsel the student, conduct a gynecological exam, arrange for the student to obtain contraceptives, and then meet with the student monthly to assure that the student is using the method of birth control properly without side effects.
- If a female student becomes pregnant, the clinic can provide prenatal care, postnatal care, and, in some cases, day care.
- If a student needs care not provided by the clinic, the clinic can make the appropriate referrals to other agencies.

What Is the Evidence for the Success of Clinics?

There are various types of evidence that clinics work. First, the rapid growth of clinics means that at a minimum clinics have gained the acceptance and support of many communities. Moreover, where they have opened, they have gained the respect and even greater support of parents and other community members.

A second type of evidence is provided by the clinic statistics on usage. In many schools, when clinics first open, students initially do not know about the clinics or are reluctant to use them. However, in most of the schools, the clinics do prove themselves with the students. In Kansas City about 70% of the students use the clinic each year, in St. Paul about 75%, and in Dallas, about 80 to 90%. These are high usage rates, especially when many of the remaining students may not need to use the clinic each year. Some of the smaller clinics have lower usage rates, but typically this is because limited funding prevents the clinics from being open a greater number of hours.

Third, many of these clinics are finding previously undetected health problems and are providing a wide variety of care that the

youths might not otherwise have gotten. For example, last year the clinic in Dallas found previously undetected health problems in an estimated 20 to 30% of its patients, including more than 100 undetected heart murmurs. Each year that same clinic treats more than 3,200 youth in 11,000 clinic visits for a wide array of health problems.

But these statistics still do not answer the important questions about pregnancy: Do clinics reduce the amount of unintended pregnancy and childbearing? Do they reduce the dropout rates among teenage mothers? Several clinics have clinic usage data indicating increased use of contraception obtained from the clinic, but most of them have not yet conducted evaluations to determine the impact upon pregnancy.

The greatest amount of research has been conducted on the St. Paul clinics. Most of the evidence for the success of that program is based upon the clinics' records and the staffs' knowledge of births among students. Thus, the data undoubtedly do not include all births.

During the three years that the clinic was open at Mechanic Arts High School:

- the known fertility rates dropped from 79 to 35 births per 1,000, a decline of 56%,
- the dropout rate among girls who delivered and kept their children declined from 45% to 10%,
- the use of contraceptives by those adolescent mothers increased to 100%.

These figures are based upon a student population of 1,002 students.

After Mechanic Arts High School closed, clinics were opened at two schools and eventually two more. Over a period of several years at these schools:

- the percentage of female students receiving family planning services from the clinics increased from 0% to about 35%,
- the 12 month and 24 month contraception continuation rates were 93% and 82%,
- the birth rates among non-Southeast Asians dropped by about half,
- 80% of all adolescent mothers remained in school,
- only 1.4% of the adolescent mothers who remained in school had a repeat pregnancy within two years or until graduation.

Thus, the St. Paul clinics apparently increased the use of birth control, facilitated the continual and proper use of birth control, and decreased births. An analysis of positive pregnancy tests in the clinic indicated that most pregnant teenagers went to term. This strongly suggests that the birth rates are declining not because of an increase in abortions, but because of a decline in pregnancies.

Although there is considerable evidence to document the success of the St. Paul clinics in reducing pregnancy and birth rates, it would not be prudent to conclude that all the clinics are this successful. The St. Paul program is one of several programs that has been relatively well funded; other clinics have had much less funding. Moreover, the St. Paul clinics give considerable attention to preventing pregnancy—they provide consultation, conduct pelvic exams, write prescriptions, help arrange the filling of those prescriptions, and do careful follow-up. Not all clinics give family planning such attention. Although the evidence is not yet compelling, there is some preliminary evidence indicating that at least a few of the clinics which pay little attention to family planning have a proportionately minor impact upon pregnancy and birth rates.

Nevertheless, the data from the St. Paul clinics strongly imply that school-based clinics can have a positive behavioral impact upon health and pregnancy. Thus, they should be replicated and studied elsewhere.

Is Anyone Currently Conducting Additional Research on the Clinics?

Several clinics are conducting evaluations of their operations. The Robert Wood Johnson Foundation, the Ford Foundation, and possibly other groups are also conducting evaluations of a few sites.

The Center for Population Options is currently evaluating about 10 clinic programs throughout the country. That research will measure more accurately the impact of school-based clinics upon unintended teenage pregnancy, de-

termine which aspects or characteristics of the clinic model are most important to reducing teenage pregnancy, measure positive effects of the clinics in other health areas, assess the cost effectiveness and cost benefits of different approaches, and determine which methods of implementing programs are most effective.

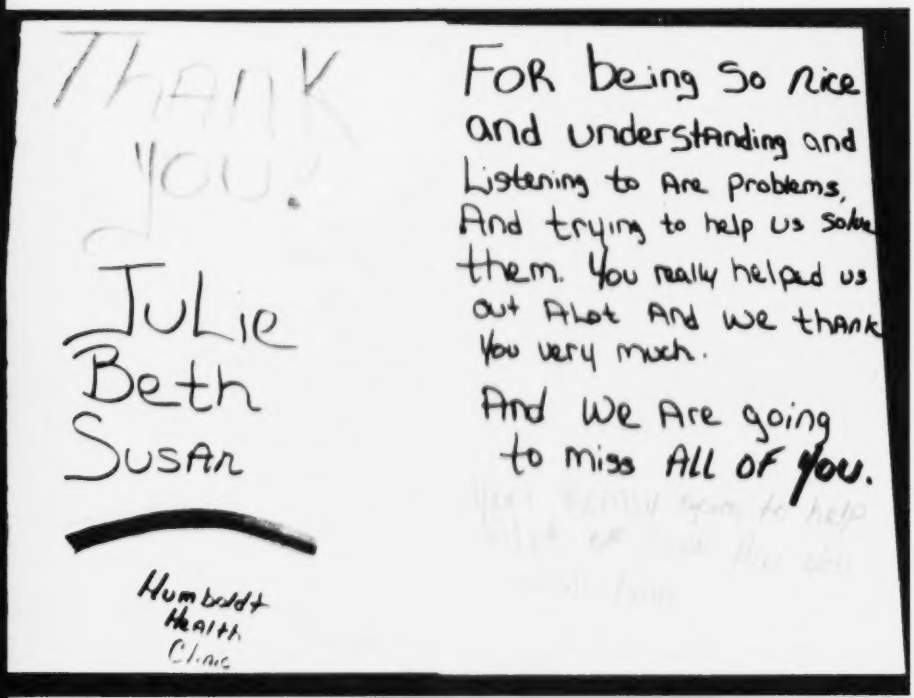
Although that study will not be completed for a couple of years, some results will be released as they are obtained. Douglas Kirby who is directing that research, is also helping others set up methods of evaluating their programs.

What Do Clinics Cost?

The costs of the clinics vary greatly, depending upon their physical size, their staffing, and services they offer, and the types of costs included. The range seems to be from about $25,000 to $250,000 per clinic annually. The lower figure does not include donated space or services, nor a proportionate share of overhead for running the program. The latter figure includes most everything. Moreover, the clinics operating on lower budgets obviously cannot be open as many hours nor provide as many services.

A more descriptive figure is $100 to $125 per student per year for reasonably comprehensive care. These figures are based upon the number of students using the clinic for all services, not upon the number of students in the school.

To some people, providing primary health care to adolescents for $125 per year may seem like a bargain, given the improvements in the adolescents' health. To other people, the clinics may appear very costly. This latter group should fully realize that these clinics will save


THANK YOU!
JULIE
Beth
SUSAN
For being so nice and understanding and Listening to Are problems, And trying to help us Solve them. You really helped us out ALot And We thank You very much.
And We Are going to miss ALL OF you.
Humboldt Health Clinic

The medical costs, welfare costs, and other costs to society of emergency care, unintended teenage births, and low birthweight infants are undoubtedly far greater than the costs of these clinics.

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many tax dollars, if they reduce the use of emergency medical care or prevent only a few unintended pregnancies and births, only a few problem pregnancies, or only a few low birthweight infants. The medical costs, welfare costs, and other costs to society of emergency care, unintended teenage births, and low birthweight infants are far greater than the costs of these clinics. Thus, these clinics have the potential to both save money and provide needed medical care.

How Are Clinics Funded?

Funding the clinics continually challenges the clinic administrators. Their task has been especially challenging because in the 1980's most social service programs have been frozen or cut back, and few new programs have been initiated. Thus, the clinics' success clearly demonstrates their administrators' creativity, expertise, and determination in the face of tight monetary constraints.

Most clinics have combined funding from federal, state, and local public and private monies. Despite their success in creating this mix, many sites have stated the need to move away from a mix of monies—at least the haphazard mix—to a blend of funds or to a single funding source that is designed for school-based clinic sites and thus is more stable. This is the challenge for clinic administrators in the years ahead.

The following overview of clinic funding sources is based upon a survey of just eight organizations which collectively run 21 clinics. Consequently, this analysis offers funding trends rather than definitive data.

Public funding. The level of public funding received by the eight programs is generally quite high. All eight programs reported receiving some public support. Two programs are publicly supported 100%, another two are around 95%, with others at 80%, 55%, 30%, and 5%.

Block grants. Of the public monies, most come from the Maternal and Child Health (MCH) block grant. These are federal funds given to the states with wide discretion in both allocation and administration. Four of the eight programs reported receiving MCH funding. MCH funds account for 50% of the budget of three programs and a full 90% of the fourth.

Sites which have utilized MCH block grants have generally experienced cutbacks in recent years as the federal funding level has fluctuated. In addition, those sites are often at the mercy of state policies which determine how the limited funds will be allocated. Frequently in states, there is a struggle between those who advocate geographic equity—in which all areas of the state get a set amount of funds—and those who advocate allocation based on "need." In many communities, the school clinics are located in areas of need. Thus, their funding is likely to be enhanced if state policies are based upon need.

Significantly, only one of the eight programs appears to tap the Social Services Block Grant (SSBG), Title XX, for family planning monies. This same site also uses Title XX for funding its day care services. Without the day care component, it might not have considered Title XX.

Other state sources are tapped by two sites. One utilizes a special Children's Trust fund and another a Community Health Services fund.

Federal (non-block) funds. Few programs utilize federal funds from "non-block" sources such as Title X, Title XX, and Medicaid. For example, only one program reported receiving Title X funds from the national family planning program. Another site reported receiving Title XX Adolescent Family Life Act (AFLA) monies totalling 42% of its budget. Significantly, only two programs reported billing through Medicaid. For one of those sites, Medicaid billings total over 5% of the current program income.

Most clinics have combined funding from federal, state, and local public and private monies.

Medicaid reimbursements as a source of clinic support deserve further exploration since they do have advantages: Medicaid is an entitlement program; it can fund a sizeable part of a budget; and the calculations of reimbursement income and administrative cost outlay are fairly straightforward. As early as 1975, the two elementary school clinics in Posen/Robbins recovered 20% of their operating expenses from Medicaid. More recently, several emerging sites are intending to make greater use of Medicaid funds and are developing special arrangements with Medicaid for billing so that confidentiality is not destroyed.

To assess whether it makes sense for a program to embark on the administrative requirements associated with Medicaid reimbursement, a clinic needs to examine not only the numbers of Medicaid *certified* but also the numbers of Medicaid *eligible* in their population. If certification is

the major barrier to obtaining significant income for a program, then it may be useful to find a mechanism to address certification—by convincing the appropriate authorities to place a certification worker in the clinic, by transporting clients to the certification worker, or by some other innovative arrangement.

Other federal funds. One site, Dallas, has successfully tapped the National Health Service Corps for the equivalent of 22% of its budget. However, that program has been subjected to recent budget cuts. Some clinics have obtained special contracts and grants for demonstration activities and research. These, however, often require considerable time and effort to write, and of course, may not be funded. Other programs such as EPSDT also need to be explored.

Local funds. Of considerable interest is local support—tapped by all programs in amounts ranging from 5% to 30% of their budgets. Most sites also secure very valuable in-kind support.

Local city funds. Three programs secure local city funds. The funding levels tend to be small. That's not surprising, because most clinics are located in poor communities with a small tax base. To the extent that the clinic site is part of a pocket of poverty within a wealthier community, there is greater likelihood of tapping a larger tax base.

Local in-kind support. While in-kind support may be a relatively small part of most budgets, it's a larger part of the financial picture. In-kind space and utilities associated with that space are the most common resources. Some clinics also receive some time and support from the staff of organizations, e.g., the schools' registered nurses and other departments' social workers, counselors, or administrators.

Private funds. Foundations play a significant role, since most sites report some level of foundation support. For example, the Robert Wood Johnson Foundation has funded numerous clinics, often for several years. Many local foundations have also provided support. While most foundations are unable to provide continuing support for direct services, they are able to give grants for startup activities and demonstration programs.

A few sites are engaged in collecting private monies through insurance companies and patient fees. Others ardently stay away from these avenues, believing that the additional administrative cost is greater than the funds received.

Fee-for-service. Most clinics provide their services free of charge. However, at least two clinics charge a small annual fee of about $12. If students cannot pay that fee, they are allowed to use the clinic anyway. These clinics have two reasons for charging such fees. First, they believe that it teaches the students an important aspect of health care. Second, the fees actually bring in a significant amount of funds, almost $40,000 per year for one clinic.

What Are the Limitations of the Clinic Model?

Although the school-based clinic model appears to have a number of important advantages over other health delivery models for adolescents, the model does have some limitations. A major limitation is, of course, that clinics do not currently have a stable source of funding as do some other health delivery systems. And there are other limitations: clinics located in the school building often cannot serve non-students; some teenagers might prefer a non-school setting; clinics which do not fill prescriptions (e.g., birth control pills) force students to go elsewhere to have those prescriptions filled; clinics have limited hours and cannot provide service during non-clinic hours; coordinating referrals and other arrangements with other agencies can be cumbersome and time-consuming; some state or school requirements thwart the provision of some kinds of needed health care. All these limitations clearly indicate that school-based clinics can only partially fill the health and family planning needs of teenagers, and that other programs should be maintained and enhanced.

The available evidence indicates that this clinic model is a promising one that should be expanded.

There is another potential problem—eventually clinics may open in more middle class communities and may compete with existing private providers of health care. This may raise concerns about the proper role of private versus government funded health care. This, however, is a potential problem for many providers of health care, reflecting a debate that may not be resolved for some time.

Despite these current limitations and possible future problems, clinics are now providing effective health care to thousands of adolescents who need care, but who would not otherwise receive it. The available evidence indicates that this model is a promising one that should be expanded.

PROGRAM IMPLEMENTATION

Agencies have had different experiences in opening clinics. In general, the process of organizing a school-based clinic is long and arduous, usually taking at least one year and sometimes longer. When the clinic has been located in more urban areas with more complex or more bureaucratic institutions, then the effort required to obtain the needed approval and to open the clinic appears to be greater. However, once a clinic is established in one school in a community, it often takes much less effort to open additional clinics. In fact, principals sometimes observe the success of the first clinic and then want clinics for their own schools.

Some clinic staff have commented that opening a clinic in schools is remarkably like opening clinics elsewhere in the community. Other sites have found it quite different.

Following is an outline of recommended steps to follow in order to implement a program. This outline is not a detailed guide and cannot present all the relevant issues. Thus, you should definitely obtain expert advice from others who have successfully opened clinics.

Although the steps below are presented in a chronological order, you may need to complete several steps simultaneously, and commonly you may need to reverse the order of some steps as you proceed.

1. **Assess Community Need**
   - Gather statistics on unmet adolescent health needs and on teenage pregnancy in your community.
   - Become more familiar with the research on adolescent health and teenage pregnancy.
   - Keep a file of anecdotes, stories, letters to the editor, local events, and other materials that demonstrate in a more personal and humanistic way the need for a clinic.
   - Informally canvass parents, students, and others about their interest in supporting a program.

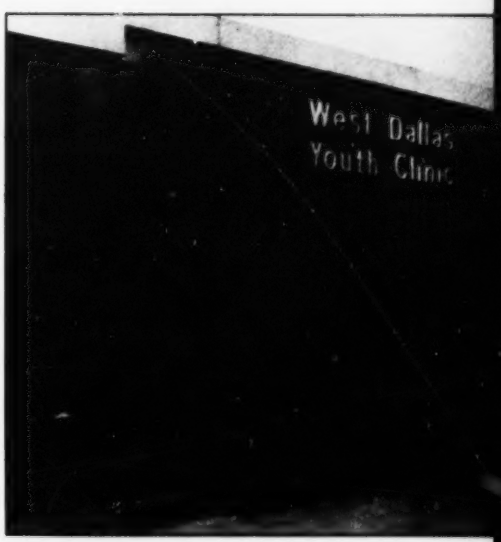
2. **Involve Others Who Share Your Concerns**
   - Talk with others in your own organization who would be receptive.
   - Meet informally with people in other organizations concerned with adolescent health and pregnancy.

3. **Gather Information on Similar School Programs**
   - Contact resource people knowledgeable about clinics.
   - Visit an effective school-based clinic.

4. **Select Basic Goals for the Clinic**
   - Be sure to include health needs and not just family planning.
   - Decide whether the clinic will serve only students or also other adolescents.

5. **Consider Several Schools and Then Select One**
   - Use the following criteria: the health needs of the student populations, their pregnancy rates, the extent to which the area is medically underserved, and the receptiveness of the school authorities and the community.

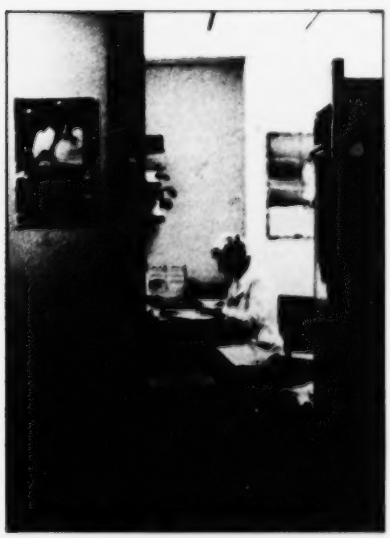
6. **Approach the School System**
   - Talk first to those who would be most receptive.
   - Include in your early discussion the Superintendent of Schools, the principal, counselors, school nurse, and other interested personnel (but not necessarily in that order).
   - Emphasize the comprehensive nature of the clinic program.
   - Emphasize that the clinic will contribute to the educational aims of the school by teaching about health, detecting early any health



problems that might hinder learning, and helping to keep students in school.

7. Establish an Advisory Committee

- Consider establishing part of this committee before selecting the school.
- Include people representing the school, the students, the medical community, parents, the clergy, representatives of youth serving agencies, and community leaders.
- Limit the number of members to a small working group (e.g. 8 to 10 individuals).
- Include only people who are basically supportive of the idea, but be sure to include people representing various political viewpoints in the community.
- Clearly define their role at the beginning (e.g. to set policy, raise funds, provide community support); also define the length of their involvement.



8. Determine What Services Will Be Offered

- Develop a core set of medical and social services based upon student needs, funding, staffing, and community acceptance.
- Try to make these services as comprehensive as possible.

9. Establish Linkages with Other Youth Serving Agencies

- Make arrangements with departments of public health, drug and alcohol abuse programs, and other agencies for the part-time staffing that they can provide.
- Coordinate procedures for making referrals to other agencies.

10. Select Possible Location for the Clinic

- Decide whether it will be in the school building and serve students only, or will be adjacent to the school, but on school grounds and serve other adolescents in the community.
- Try to have a convenient, centrally-located space, which students pass frequently and where they can drop in easily.
- Plan sufficient space for the clinic activities and staff offices.
- Also plan sufficient space for separate counseling and examination rooms where others cannot overhear the conversations or examinations.

11. Obtain Tentative Approval from the Appropriate School Authorities

- Obtain a clear understanding of the obligations of the school (e.g. to provide space, utilities, and maintenance), the clinic goals and activities, and procedures for obtaining parental consent.

12. Determine Budget and Obtain Funding

- Obtain a planning grant prior to this step, if necessary.
- Develop a 2-5 year budget.
- Identify in-kind support from local agencies.
- Identify possible funding sources.
- Make preliminary contact with potential funders to determine interest.
- Obtain accurate information about criteria for proposals.
- Write proposals.
- Try to obtain multi-year funding from stable sources.
- Determine most effective marketing strategies, e.g. emphasize with local funders that the program will probably save money in the long run by reducing the number of unintended teenage births and the amount of emergency medical care.
- Negotiate Medicaid arrangements, if Medicaid is to be used.

13. Obtain Formal Approval from the Appropriate School Authorities

- Obtain a written agreement specifying the responsibilities and goals of the clinic and school.
- Obtain approval from all the necessary school authorities, e.g. the Board of Education, the Superintendent of Schools, and the principal.

14. Design the Clinic

- At a minimum, have an intake waiting room and a separate room for counseling and examinations. If possible, have three or more rooms.
- Design the clinic to enhance confidentiality. For example, do not use a specific room for only family planning.
- Make arrangements for the storage of confidential health records.
- Make the clinic colorful, cheerful, and approachable.
- Have the students help decorate the clinic.
- Have brochures, pamphlets, and posters in the clinic for the students to read while waiting to see the appropriate staff person.

15. Select Staff

- Select staff that enjoy youth and have rapport with them; are trained in appropriate specialties; and will create and maintain good working relationships with the students, the school, parents, and other agencies involved.
- At a minimum, have a nurse practitioner, a social worker or counselor, and a medical assistant.
- Either have a physician part-time or full-time, or have a physician who establishes the protocols and is available for consultation and referral.
- Consider having the following health professionals either part-time or full-time: obstetrician/gynecologist, specialist in adolescent medicine, family planning or ob/gyn nurse practitioner, pediatrician, pediatric nurse practitioner, social worker or counselor, nutritionist, health educator, sexuality educator, dental hygienist, dentist, lab technicians.
- If there is already a school nurse, consider involving that nurse in the clinic as much as possible, and clearly define the respective roles of the nurse and clinic.
- Avoid having in the clinic too many staff who are there only a few hours per week.
- Have sufficient staffing for flexible hours so that students can drop in without always having to make an appointment.

16. Gain Acceptance in the School and Publicize the Clinic

- Express interest in the students wherever they are. Talk with them in the hallways, at lunch, at athletic events, and elsewhere.
- Offer free physicals to the football players and other athletes.
- Conduct immunizations for all students.
- Send out flyers or notices to the students describing the clinic and the services it offers. Make announcements over the public address system.
- Give presentations about the clinic and its services in health classes and other appropriate classes.
- Hang posters about the

clinic throughout the school.

- Conduct informal discussion sessions, show films, and have other special events in the clinic.
- Hold an all day health fair staffed by clinic personnel.
- Hold special non-health programs, e.g., ear piercing or self-defense.
- Write a regular column in the school newspaper on matters related to health.
- Attend faculty meetings and informally meet with faculty in the faculty lounge.
- Be especially careful to develop warm and cooperative relationships with the existing school nurse and counselors. Consider giving them a definite role in the service delivery plan.
- Keep the principal informed of your successes as well as any problems.

17. Maintain Community Support

- Once the clinic is open, do not forget the community. Continue to give presentations.
- Continue to meet with the Advisory Board and discuss both successes and problems.
- Each year, keep parents informed and obtain their consent.
- Each year, inform new parents by sending home a description of the clinic and requesting parental consent.

18. Develop Good Relations with the Press

- Initially, try to maintain a low profile.
- After the clinic is set up, find reporters that support the clinic and prepare for them news releases which focus upon the comprehensive health care of the clinic, its acceptance among the parents and students, and its success in meeting health needs.
- Beware: some reporters may try to focus upon the most controversial aspects of the clinic, such as providing contraception.

19. Continually Evaluate the Program

- Collect and tally statistics on the number of people served and the purposes of their visits.
- Try to keep track of changes in STD rates, pregnancy rates, and rates of other diseases.
- If possible, keep track of decreases in the number of school absences.
- Determine, if possible, the contraceptive continuation rate of those using the clinic for birth control.
- Keep track of the increases in the number of teenage mothers who give birth and then return to school.
- Conduct a needs assessment of students in the school in order to determine what needs are not yet being met.
- Talk with others who are evaluating their clinics; consider using a nearby university to help evaluate your program.

The Support Center for School-Based Clinics at the Center for Population Options (CPO) can provide technical assistance for agencies initiating or expanding clinic programs. Specifically, CPO can help in the following areas:

- Proposal writing
- Program design
- Available resources
- Provision of speakers
- Information updates
- Staff training
- Evaluation

To discuss program needs and assistance possibilities, contact:

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ADDRESSES OF SCHOOL-BASED CLINICS

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